

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011799	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/18/2015
NAME OF PROVIDER OR SUPPLIER GREENBRIAR VILLAGE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8800 SPOON DR INDIANAPOLIS, IN 46219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00174264.</p> <p>Complaint IN00174264- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey Dates: June 17 and 18, 2015</p> <p>Facility number: 011799 Provider number: NA AIM number: NA</p> <p>Census bed type: Residential: 103 Total: 103</p> <p>Census payor type: Medicaid: 8 Other: 95 Total: 103</p> <p>Sample: 4</p> <p>Greenbriar Village LLC was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00174264.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE